Grand Traverse Internal and Family Medicine

Authorization for the Use and Disclosure of Protected Health Information form

Please complete the following and send to your previous physician

Release Records from:

Name of former Physician or Clinic: _____

Address: _____

1 authorize the above person or entity to release the following *(Please select all that apply):*

___ *Medical records **(ONLY LAST 2 years seen)**

**includes medical summary with current problem list, medications, and allergies, most recent EKG, latest H&P, last 1-year of lab/test results, consult and progress notes*

___ Most recent Colorectal Cancer Screen (or documentation of Colectomy)

___ Most recent Cervical Cancer Screen (or documentation of Hysterectomy)

___ Most recent Breast Cancer Screen (or documentation of Mastectomy)

___ Most recent Bone Density Test

__ Most recent Diabetic Retinal Eye Exam

__ Other *(Please specify)* _____

For the purpose of: _____ Continuation of Care _____ Insurance

_____ Legal Reasons _____ Other *(please specify, below)*

{Specification of "other") _____

Only the above-referenced information may be used and/or disclosed pursuant to this authorization

Send Records to: GTI 5015 N. Royal Dr. Traverse City, Mi 49684 Phone: 231-935-0850 Fax: 231-935-0869

Dr. Oakley **Dr. Klettner** **Dr. Bultemeier** **Dr. Yates** **Dr. Hughes** **Dr. Schreiber** **Dr. Kohler**
Dr. Vollbrecht **Jessica Mastbergen, DNP**

I understand that, if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, such information may be re-disclosed and would no longer be protected.
I understand that I have a right to revoke this authorization at any time. My revocation must be in writing and submitted to the Privacy Officer at Grand Traverse Internal and Family Medicine. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

This authorization expires **1 year from signature date.**

I understand that I have a right to inspect and copy my own protected health information to be used or disclosed (in accordance with the requirements of the federal privacy protection regulations found under 45 C.F.R 165.524).

I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from Grand Traverse Internal and Family Medicine, nor will it affect my eligibility for benefits.

_____ _____
(Signature) *{Date)*

_____ _____
{Name - Print) *{Date of Birth)*

_____ _____
{Name of Personal Representative) *{Relationship to Patient)*